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Health consequences of child removal among Indigenous and non-Indigenous sex workers: Examining trajectories, mechanisms and resiliencies

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Abstract

The child protection system can be a highly consequential institution for mothers who are sex workers, yet scant attention has been paid to the health consequences of its policies on this population. Drawing on 31 in-depth, semi-structured interviews with 19 Indigenous and 12 non-Indigenous sex workers in Vancouver, Canada, and using the stress process model and the concept of slow violence, this study proposes a typology of four trajectories through which child removal by this system shaped sex workers' health. Results suggest that child removal has health consequences beyond the conventionally thought of mechanism of mental distress and related health sequelae, to additionally alter women's social conditions, which also carried risks for health. Notably, while trajectories of Indigenous and non-Indigenous

Abbreviations: CPS, child protection system.

[1]The term 'Indigenous' is used throughout this paper to describe peoples who are descendants of the original inhabitants of a territory before colonial influences and have preserved intact customs and traditions of their ancestors although placed under a state structure characterized by national, social and cultural characteristics which differ from their own. In Canada, "Indigenous" describes First Nations, Métis and Inuit peoples. We note that while this term replicates colonial discourses, the diversity of cultures, languages and traditions that exist among Indigenous peoples is acknowledged and respected.

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sex workers were similar, Indigenous participants, whose families are disproportionately impacted by long-standing colonial policies of child removal, were more severely jeopardized. Findings highlight how child removal can enact violence in the form of reverberating harms to sex workers' health, further reinforcing their marginalized statuses. This study calls for greater attention to how the child protection system (CPS) may influence the health of marginalized mothers, including how health inequities may be both causes and consequences of interventions by this system.

KEYWORDS
Child protection, Sex work, Child custody loss, Indigenous, Historical trauma, Stressors, Maternal health, Canada

INTRODUCTION

Background

The child protection system (CPS) can be a highly consequential institution for marginalized mothers, who amid intersecting forces of poverty, racism, colonialism and criminalization, are often faced with temporary or permanent termination of parental rights (Dewey et al., 2018; Hester & Westmarland, 2004; Sloss et al., 2004). While much of the literature to date focusses on understanding the outcomes of children removed from their homes by CPS, there has been far less attention to the outcomes and experiences for birth mothers (Runyan, 2018), virtually all of whom are economically and/or racially marginalized, and thus already facing a high burden of adversity. Aiming to think more expansively about this system through its potential health consequences on mothers, this paper considers the trajectories through which events of child removal affected health in a Canadian sample of sex workers, a majority of whom were Indigenous[1] and faced intergenerational separation of their families due to historic and ongoing colonialism.

Mothers who are sex workers can face an accumulation of stressors in their lives influencing the likelihood of child protection intervention into their families, yet their reproductive health and mothering experiences are rarely accounted for in research (Duff, Bingham, et al., 2014; Duff, Shoveller, et al., 2014). Inattention to these issues obscures the conflicts sex workers encounter with cultural norms of mothering, and the consequences of their socio-legal and moral framings as fundamentally risky and dangerous to their children (Dewey et al., 2018). As mothers, sex workers are often stigmatized (Sloss et al., 2004), contending with 'society's diametrically opposed perceptions of sex worker and "good mother" (Dodsworth, 2014: 1)'; 'dual identities', which may be more difficult to navigate when sex workers are living in poverty (Dewey et al., 2018). Stigma facing these mothers can also be reinforced by criminalization policies, the dominant public policy approach to the sex industry, which can confer additional risks to sex workers and, in turn, create barriers to accessing health, social and legal services for themselves and

their children (Sloss & Harper, 2004). Given these contexts, women sex workers frequently contend with a formidable fear of losing custody of their children (Dodsworth, 2014), with several studies pointing to a high burden of child removal in this population (Duff et al., 2011; Duff, Bingham, et al., 2014; Sloss et al., 2004). One Canadian study by Duff, Bingham, et al. (2014), Duff, Shoveller, et al. (2014) also showed a high rate of intergenerational child removal among sex workers, which was found to be markedly higher among Indigenous sex workers (Duff, Bingham, et al., 2014). a phenomenon recognized as inseparable from ongoing colonial policies in Canada, which is also closely linked to the over-representation of Indigenous women in sex work (Bingham et al., 2014; Hunt, 2013).

Among Indigenous sex workers, colonialism and child removal are closely interconnected in settler-colonial jurisdictions (Hunt, 2016), reflecting continuity with centuries of colonial violence towards Indigenous families, which has also led to the long-standing disempowerment of Indigenous mothers and matriarchal structures as primary targets of colonial intervention (Turpel, 1993). In Canada, this violence included the Residential School System, which, for almost 400 years, was used by government-church actors as a tool of domination and genocide (National Inquiry into Missing & Murdered Indigenous Women & Girls, 2019), sanctioning the forced removal of 150,000 Indigenous children as young as 3 years old from their parents and communities (Blackstock, 2015). This system, which forged conditions for horrific sexual, physical and emotional abuse, illness and mass deaths of Indigenous children (Truth & Reconciliation Commission, 2015), was eventually replaced beginning in the 1960s through 1980s by settler-state-led initiatives of forced adoption of thousands of Indigenous children into white families, referred to as the 'Sixties Scoop'. Currently, in the latest iteration, these institutionalized colonial dynamics are observed in the significant over-representation of Indigenous children in Canada's foster care system, also known as the 'Millennium Scoop' (Sinclair, 2007). Further, colonial child removal policies have also been instrumental in upholding other forms of settler-colonial violence that have mainly targeted Indigenous sovereignty over lands, observed in the massive dislocation of Indigenous communities to reserve areas and ongoing systems of economic marginalization, which are at the root of many of the structural inequities faced by Indigenous families today (Blackstock, 2015; Gracey & King, 2009; Walters & Simoni, 2002).

Though child removal policies are widely recognized as forms of genocide and collective trauma for Indigenous peoples (Duran & Duran, 1995; Heart & DeBruyn, 1998; Million, 2013), their effects have not been adequately documented in the indexed health literature, which as Smylie (2014) points out still systematically prioritizes non-Indigenous experiences (Smylie, 2014). Thus, though a growing literature has directly examined the health effects of the Residential School System on Indigenous peoples' health (Bombay et al., 2014; Hackett et al.,l., 2016; Kaspar, 2014), there has been no systematic analysis of how current child removal policies are affecting the health of Indigenous peoples, and Indigenous mothers in particular.

Looking more broadly at health outcomes among women intersecting with CPS, a growing body of health research in North America has connected events of child removal to several negative health outcomes for mothers, including poor mental health, (e.g. suicidality, depression, anxiety, post-traumatic stress), substance use and premature mortality (Haight et al., 2002; Kenny et al., 2015; Nixon et al., 2013; Wall-Wieler, Roos, Bolton, et al., 2017; Wall-Wieler, Roos, Brownell, et al., 2017; Wall-Wieler et al., 2018). Related research also points to ways that experiences with CPS can reinforce adversity in mothers' lives, through stigmatizing labels, expansive surveillance, and collateral losses of housing, income and social support (Broadhurst & Mason, 2017; Fong, 2020; Hook et al., 2016; Kenny & Barrington, 2018; Sykes, 2011; Wall-Wieler, Roos, Bolton, et al., 2017). Turning to the experiences of sex workers, the link between CPS encounters and

health has been largely unstudied, with a small number of studies from North America and the UK documenting that child removal is associated with elevated mental distress and substance use (Dodsworth, 2014; Jackson et al., 2007; Jeal et al., 2008), overdose risk (Thumath et al., 2020), increased frequency of sex work (Dewey et al., 2018; McClelland & Newell, 2008) and worse self-rated health (Kenny et al., 2019).

Conceptualizing links between child removal and women's health

To date, much of the scholarship focussing on events of child removal to CPS and women's health is descriptive and has offered limited insight into mechanisms that may explain the dynamics of maternal health decline. We begin to address this shortcoming by drawing on the stress process model and the concept of slow violence, with the aim of examining the processes underlying the relationship between child removal and sex workers' health.

The stress process model is frequently applied to examine how a stressful life event ('primary' stressor) can be a source of acute and chronic stress, both by the event having direct effects on health, as well as indirect effects through the triggering of 'secondary' stressors, which can accumulate over time to further worsen health (Pearlin, 1989). Though often applied as a sociological framework for understanding the relationships between institutions such as the criminal justice system and health (Sirois, 2020; Sugie & Turney, 2017), attention to these issues in the case of CPS and the health of mothers is a theoretical addition to the literature. Three key aspects of the model are helpful for our analysis. First, this model directs explicit attention to the ways that traumatic stressors like child removal are disproportionately concentrated in sections of the population who are racially, economically and/or historically disadvantaged, thus having potentially salient consequences for inequities in health. Second, the model facilitates an examination of the mechanisms underlying the relationship between child removal and health, including consideration of both the psychological stress and the rise of 'secondary' stressors, distinct from the initial trauma, that may also exert their own harmful health consequences. Finally, the model highlights how an individual's contextual disadvantage affects how they cope with and respond to the traumatic event, a process that also has implications for health. On this model parameter, events of child removal may be especially consequential for Indigenous sex workers, who in addition to their marginalized social status as sex workers, face distinct racism and structural inequities related to colonialism shaping access to resources and support in the aftermath of these events (Bingham et al., 2014; Hunt, 2016).

While the stress process model is helpful in emphasizing domains of the ecological context that shape and may be impacted by events of child removal, its applications maintain an analytic distance from broader structural injustices that routinize these events in the lives of marginalized women. We propose an approach to bridge this gap by connecting the stress process model to the concept of 'slow violence'. Expanding on the concept of structural violence, a framing applied in health research to capture the harms afflicted by social and disciplinary structures on marginalized populations, Nixon's (2011) concept of slow violence calls attention to the temporal and spatial scales of how structural violence is deployed (Nixon, 2011). In this approach, Nixon argues that many injurious forms of structural violence gain their power over time, producing a violence of gradual or delayed destruction, where causes and consequences of violence are decoupled and dispersed rendering its origins and full range of harms less visible. As theorized, slow violence assists in conceptualizing child removal as a generative form

of state-sanctioned violence, manifested in incremental harms to maternal health across time and space, the delayed effects of which help mask its full brutality (Rezwana & Pain, 2020). We draw closely here from De Leeuw's (2016) application of slow violence in her examination of Indigenous child removal in Canada (De Leeuw, 2016). This research supports a framing of child removal as an attritional form of colonial violence towards Indigenous families, who, impoverished by systemic neglect and with few resources to fight back, can become ensnared in drawn-out custody proceedings and state interventions, the long-term harms of which, compared to other forms of colonial violence, such as pipeline expansions, are often difficult to source and mobilize against, typically occurring without any public scrutiny or a media-attracting apex. Arguing the violent cycle of family separation to be one with harms dispersed well beyond a single point in time, De Leeuw (2016) also echoes others in pointing to this cycle as a key modality of colonial power through which the dispossession of Indigenous sovereignty, culture, livelihoods, well-being and most importantly, land, are strengthened and expanded (Coulthard, 2014; Landertinger, 2017).

Informed by the stress process model and the concept of slow violence, the present study aims to expand understanding of child removal by CPS by exploring its health consequences in a sample of marginalized sex workers, for whom contact with this system is often commonplace (Dewey et al., 2018; Duff, Bingham, et al., 2014; Duff, Shoveller, et al., 2014; Hester & Westmarland, 2004). We outline four trajectories through which child removal shaped sex workers' health and point out ways that Indigenous sex workers appeared more severely jeopardized. We use the term 'trajectory' because it incorporates the concept of time—critical for understanding how the consequences of child removal can extend well beyond the event itself to exert longer-term influences on maternal health.

METHODS

Recruitment and sample

This study was conducted as part a larger longitudinal, community-based prospective cohort study–An Evaluation of Sex Workers Health Access (AESHA)—of street and off-street women sex workers in Vancouver (Canada), which builds on long-standing researcher–community collaborations, including an active advisory board of Vancouver-based sex work agencies and representation from Indigenous sex workers. Interview participants were recruited between November 2016 and May 2017 using purposive sampling. AESHA Cohort members who were 18 years or older, English-speaking, and had experienced short or long-term custody loss through the CPS were eligible to participate. Sampling was an iterative process and aimed to reflect variation in women's profiles with regard to race/ethnicities (i.e. Indigenous, white), age, terms of separation from children and current parenting status. In our sample of 31 participants, a majority were Indigenous sex workers ($n = 19$) reflecting the over-representation of Indigenous women in street-based sex work in Vancouver (Bingham, 2014). All participants provided informed consent and were remunerated with a CAD $30 honorarium.

Development of the study's interview guide was a community-engaged process. The first draft was produced by the lead author and further developed by Indigenous and non-Indigenous researchers on the study team. Community collaborators further reviewed and provided inputs on the guide to ensure questions were meaningful and accessible to participants.

Data collection and analysis

Interviews took place at an AESHA community office. Participants were interviewed by lead author (KSK), a white PhD candidate and a co-author (FR), who is an Indigenous researcher with experiential knowledge of sex work, and long-standing ties to communities where many study participants resided. All interviews were audio-recorded, lasting 20–96 min (mean: 57 min) and transcribed verbatim.

Data collection and thematic analysis occurred concurrently. Immediately following interviews, field notes were written to summarize interview content and themes. The lead author (KSK) then read each transcript and wrote analytic summaries of interviews to explore key features of individual cases and apply a timeline/chronological order to each (Riessman, 2008). A list of codes was then developed that were generated deductively based on key constructs of our theoretical framework and research objectives, and inductively, based on reading of field notes, transcripts and analytic summaries. All transcripts were coded by KSK using ATLAS.ti 8. Using coded data and analytic summaries, KSK then developed case-by-case comparison tables to establish thematic areas of interest, such as health consequences of separation and circumstances pre- and post-loss, which enabled interpretive connections between personal narrative, larger colonial and socio-structural arrangements, and Indigenous and non-Indigenous women's trajectories. Additional matrices were developed to describe key effects and mechanisms. Quotes by participants are reported using pseudonyms. The study holds ethical approval by approval by the Providence Healthcare/University of British of Colombia Research Ethics Boards.

FINDINGS

Our sample consisted of 31 women who experienced child removal, of which 27 (87%) had parental rights (of one or more children) terminated. Median age of participants was 43 years (range 27–56 years). All participants reported past or current street-based or informal indoor sex work. Nineteen women (61%) identified as Indigenous (First Nations and Métis) and 12 (39%) as non-Indigenous (all whom identified as white), and all women currently lived within the severe constraints of poverty. Though circumstances leading up to mother–child separation were not the focus of this analysis, women's accounts of how the system became involved in their lives foregrounded intersecting historic and institutional barriers, which for some Indigenous women marked a continuation of child removal across multiple generations. Almost unanimously, poverty pervaded circumstances of separations, and for almost half of participants, unsuitable housing was a key barrier to keeping their families together. Further, among all, separations occurred in ways that blurred boundaries between past and present. For example, historical removal from one's own parents, past evidence of drug use or sex work, proximity to a partner with a criminal history or having previously lost custody of children were viewed by women as part of the system's aetiology of 'risky' parenting. Overwhelmingly, participants contested grounds for child removal, with the exception of a few women who considered separations as reasonable responses to circumstances they deemed unsuitable for parenting due to material constraints, an internal discrediting of themselves as mothers, or both.

Below we describe a typology of four trajectories through which events of child removal influenced women's health, including (1) severe mental distress; (2) poverty; (3) social isolation and displacement; and (4) caretaking and family regeneration.

Severe mental distress

All women articulated immediate and severe mental distress following separation from their children, visible in their accounts of trauma, depression, grief, anger, and, for a few participants, the contemplation or attempt of suicide. Recalling moments following separations, women spoke of how the sudden absence of children as the central vocal point of their lives conferred, in many cases, an unbearable sense of void. Nina (Indigenous, 42 years) explained this as an 'emptiness', which she later noted as precipitating the onset of an anxiety condition: 'It's really hard.... you feel so empty... a piece of you is gone'. For two other Indigenous participants, this 'void' left them feeling incapable of functioning or living their day-to-day lives. In one example, Ginelle (Indigenous, 31 years) spoke of the removal of her newborn as prompting the losses of basic life skills and, importantly, her spiritual grounding:

> "Never slept, never showered, never ate, never had any self-care. Like I lost all my life skills. Like- as so much as, when I'd go to the shelter I'd leave my plates and my bowls everywhere. Because I just forgot how it was to live. Yeah, so spiritually, I don't think even think I had a spirit to be honest, you know, I totally lost it. Everything."

Bonnie (Indigenous, 48 years) similarly emphasized the affective toll as leading to a state of near death:

> "They were my life. I'd never go anywhere ... The longest I'd be away from them is to go to bingo. [...] It affected my whole life. I had nothing. I was barely clinging to life."

In the case of Kathi (white, 54 years), the mental distress of losing her two daughters were recounted in terms of a dramatic downward shift in how she felt about life and death: 'My kids were my life...you know? To the point that [once they were gone] I just, started – I didn't care if I lived or died, to tell you the truth'. Tina (white, 36 years) described a similar experience of 'not caring', which also brought to bear implications for her safety and health as a sex worker:

> "My sex work got more careless, and lot more frequent. [...]Oh I've always been, like pretty careful about condom use, but I just mean like, [I would]be in high risk situations. Not really caring if I lived or died."

Women's recollections of how separations affected their health were most often described in accounts of increased drug and alcohol use over a prolonged period, viewed as a key strategy to cope with the mental distress of losing their children As Margo (Indigenous, 50 years) described, the escalation of drinking marked an urgency to escape the reality of what had happened: 'It was just a lot of drinking. Lots of escaping. Just not wanting [to feel] – Disassociation, right?' In another example, Amanda (Indigenous, 40 years) explained using drugs for the first time: 'It's what got me into drugs... I couldn't figure out how to deal with the pain'. Notably, how and where women used drugs and the safety of drugs also influenced women's health. For example, Ginelle (Indigenous, 31 years) described how in living with this severe stress, she used alone, used more frequently and did not take time to check her drugs, adverse circumstances that also greatly increased her vulnerability to overdose:

> "...The increase of using by myself. The increase of drug use. I would never double check whether if it really was that or this or that, I would just do it. You know because, oh there, that pain's surfacing. I need to do it now. So yeah there was lot of risk."

Elevated drug use was also described as generating other health problems, including weight loss, lack of appetite and insomnia. As explained by Tina (white, 36 years), the depression and elevated drug use that extended over the 10 years following the loss of her four children also affected her physical health:

> "Well, I think that probably the drug use goes with the mental health, which affected my physical health [...] I think the depression probably affected sleeping and eating. Like making me not sleep, and not wanna eat and stuff..."

A few women further linked experiences of separation to the rise of long-term chronic health conditions, such as fibromyalgia, and what Pamela (Indigenous, 33 years) abstractly termed a form of 'physical sadness'.

In line with the stress process model (Pearlin, 1989), these narratives point to how child removal directly influenced the mental health of women, by triggering severe mental distress that many emphasized as persisting over time. As reflected in quotes from Ginelle, Bonnie, Kathi and Tina, these events, as well as the coping significance of substance use, had immediate and far-reaching consequences for women's health functioning and overall well-being, contributing to increased risk of occupational injury, ill health and even death. Drawing on insights from Nixon (2011), these acute and chronic health harms help illuminate how the slow violence of child removal gained traction in women's lives, taking a considerable toll on their wellbeing and potentially leading to a wearing away of health across time.

Women's accounts of health following the loss of their children were also inseparable from their colonial and institutional histories, which for Indigenous participants included widespread intergenerational CPS involvement and distinct accounts of childhood trauma through this system. This trauma history was pointed to as severely compounded when their own children were taken by the same system. For example, in the case of Vicky (Indigenous, 38 years), forcible family separation had occurred over four generations: her grandmother and mother were removed from their families and forced to attend Residential School, she was taken from her kindergarten classroom by a social worker and moved to dozens of different foster homes, and her first-born child was removed at birth. Reflecting on these experiences, Vicky's fear of a similar cycle repeating itself in her first-born's life was recalled as triggering extreme stress and worry, which eventually led her to withdraw from custody proceedings, opting for adoption so that her child would not be shuttled around the system like she had been. This acutely heightened fear of the system and inability to protect children from its harms was further echoed by a small number of other Indigenous women, all of whom had suffered physical and sexual abuse in foster care as children, and for whom, the reality of their own children being involved in the same system was exceedingly brutal and a very real source of harm to their mental health. In elaborating on this point, Esther (Indigenous, 51 years) stressed how her daughter's removal also marked a continuity of systemic indignities towards Indigenous peoples that fostered the sense of being essentially disposable: *[The system] instilled in my daughter that she was not valuable... which we've been getting taught as First Nations women for generations... that we're not valuable and when you get [taken] from your own family, it is even that much more scarring*. Importantly, these examples

demonstrate how the repeated waves of violence caused by intergenerational family separation, as well as the fear of Indigenous children facing a similar fate of abuse in the hands of CPS as their parents—outline distinct dimensions of colonial violence affecting the mental health trajectory of Indigenous participants that did not similarly afflict white participants.

Poverty

Beyond the burden of mental distress and related risks to health, child removal was also linked to accounts of worsening poverty, a phenomenon which more frequently impacted Indigenous participants. Increased poverty was most often evident in women's loss of housing and increased reliance on street-economies, which the stress process model (Pearlin, 1989) elucidates as evidence of the indirect proliferation of 'secondary' adversities that can materialize as consequences of the initial traumatic event to exert their own detrimental effects on health.

Loss of housing in the aftermath of child removal most often resulted in participants becoming homeless. Reflecting on this period, women pointed out several barriers to maintaining their housing. For example, some participants in subsidized housing described no longer qualifying to live in their homes without their children. A few others reported being ostracized in rural communities because of what happened with their children and subsequently forced to relocate to Vancouver with few material resources to adequately house themselves. In a contrasting example, Susan (white, 34 years) recalled feeling emotionally incapable to return to the apartment she shared with her 3-year-old son due to triggering of memories, and instead went, in her words, 'off the deep end', which implied prolonged homelessness of several years during which she had no contact with her son. Alice (Indigenous, 56 years) recalled a similar trajectory, illustrating how her mental distress and chaotic drug and alcohol use led to cascade of multiple losses, including her housing:

> "The mental health aspect of it was really, really hard. It was hard to go to work every day and, keep my head up, you know, so I delved into [drugs and alcohol]. Every time I got paid I started smoking crack and I started drinking a lot and I lost my housing. We had a beautiful townhouse two-bedroom home in Vancouver. And so, I lost that, and... ended up homeless."

Income instability paired with increased or newfound reliance on street-economies were additional markers of women's worsening poverty. For some women, street-involvement prompted initiation into sex work, while for most participants who already worked prior to events of custody loss, several reported more frequent sex work to cover the costs associated with increased drug use. In the quote below Christie (Indigenous, 51 years) draws links between the removal of her children, drug use, street-based sex work and increased risks to her safety: 'I was grieving for my kids, and I wanted to stay high all the time. [...] I'd just go out and you know, whoever picked me up is, I'd just see dollar signs, that was it'.

As underscored by these excerpts, worsening poverty was another process that explained how child removal negatively impacted health, while also exacerbating the burden of loss-related mental distress and other health challenges, and further pushing already marginalized women into more marginalized positions that are well-documented as having significant influence on their risks of violence, poor health and increased criminalization (Platt et al., 2018). Along the lines of other examples of slow violence (Pain, 2019; Rezwana & Pain, 2020), women's accounts of the onset of hard-to-reverse structural conditions, like homelessness, also reveal how

the consequences of child removal can unfold at different scales, leading to an accumulation of material hardships and risks to health across time. Significantly, for Indigenous participants, whose experiences of colonialism and racism intersected with other marginalized identities (e.g. sex worker, person who uses drugs), these new realities of homelessness and increased street-involvement were especially life-threatening consequences due to the disproportionately high rates of violence and homicide that Indigenous women experience on a routine basis in Canada (National Inquiry into Missing & Murdered Indigenous Women & Girls, 2019).

Social isolation and displacement

Women's narratives also described widespread social isolation and displacement following the removal of their children. For some mothers, and more commonly among Indigenous women, the loss of children prompted the severing of social ties. For example, Bonnie (Indigenous, 48 years) expressed her isolation to be a direct result of shame over what had happened, leading her to cut all ties with family members who were caring for her sons, which in turn reinforced her overwhelming feelings of inadequacy as a mother. Similarly, for Alice (Indigenous, 56 years), for whom her self-imposed isolation was connected to shame and self-blame, there was also the feeling of no longer deserving happiness, thus foreclosing her pursuit of future intimate relationships. In another example, Ginelle (Indigenous, 31 years) traced how her spiral of social withdrawal, self-hate and shame led to intimate partner violence, an additional harm to her physical and mental health during this period:

> "Emotionally I was just a wreck. I had a lot of self-hate. I was really ashamed, to say, okay, I've lost my children. I'd just always say, 'oh they're staying with family'. So, I'd never actually speak the truth. With my ex-husband, we started cheating on each other, hurting each other, beating each other. You know? Throwing things out that were so sentimental, like hurting. Like, mentally and physically hurting each other... We stayed alone... in our little room - all the time."

Significantly, we did not encounter a single narrative where women felt supported by institutions or service providers in the short or long-term aftermath of separations from their children. In encounters with CPS workers, women often expressed stressful and stigmatizing interactions, where they felt punished for the adversities in their lives, particularly those related to poverty and drug use. In Eden's (white, 47 years) experience, she described feeling judged and undeserving of help:

> "They find out you're, you're an addict, sex worker, and you're shit to them. So, they don't care how they help you. If you don't know what you're doing, they're gonna screw you and they're gonna say 'we're not gonna help you.'"

These strained experiences with CPS workers added to women's mental distress, in some cases reinforcing self-blame and leading to the sense that women would inevitably fail to regain custody, which in turn led some, like Sara (white, 54 years), to disengage completely from custody proceedings:

Mentally it was just, it was so much stress... 'cause like they weren't working with me. They were doing everything they could, um to tear, tear us apart and, um, it was like-It was awful. Like I felt like I had nobody on my side. [...] I just gave up and kept using [drugs].

Lack of support from and stereotyping by CPS workers was also understood in terms of racism. For example, Bonnie (Indigenous, 48 years) recounted an overt experience of racial profiling by staff at a CPS office related to her Indigenous identity, viewed as an example of the generally unquestioned anti-Indigenous racism in Canada that is central to the over-representation of Indigenous children in CPS (Trocmé, Knocke & Blackstock, 2004).

Participants' narratives of damaged social standing, displacement, and a ubiquitous absence of support represented another health influencing trajectory that undermined their coping and access to resources, and affected if, where and how women were able to rebuild relationships with their children and families. Among Indigenous participants, for whom displacement from land/home communities and racist narratives of maternal inadequacy are long-standing sites of settler-colonial interventions (Million, 2013), these dynamics also contributed to further distance them from relationships with family, culture and land, adding to the unique challenges they faced.

Caretaking and family regeneration

Amidst indisputably difficult circumstances, women also provided insight into strategies to care for themselves and maintain or regenerate connections with their children, including reconnecting to culture, which was central to survival for many Indigenous participants.

Broadly, for both Indigenous and white participants, connection and in-person access to children were expressed as vital for their well-being. Nearly unanimously, participants described feeling more content knowing about and being part of their children's lives, and, as Susan (white, 34 years) recounted, these aspirations often held greatest possibility when children were in the care of family or friends, rather than the foster care system:

> "I knew my son was safe. You know? So that really helped me, while I was out there [on the streets]. Like there were so many girls that had kids that were in [foster care] and they didn't even know where they were. So I was always happy to know that I knew where he was and that he was safe."

Being in the best position to maintain or eventually re-establish bonds with children was also described as an important influence in women's intentions towards more stability and improved life circumstances. In the example of Bonnie (Indigenous, 48 years), there was the memory of a conversation with her mother that was pivotal to maintaining belief in herself:

> "My mom said 'They'll come looking for you. They'll figure it out'. And they did. And that's what kept me going."

In another example, Alice (Indigenous, 56 years) described the restorative power of being a good Kookum (grandmother) and caring for her grandson:

> "How do you say sorry, you know?... for not being there for them when they were growing up. ... I think that's why I took care of my grandson. You know? I taught him everything. The right way... I wanna be a good Kookum, you know...And I am."

Similarly, Violet (Indigenous, 55 years), who experienced grave harms in Residential School, recounted the importance in the context of Indigenous motherhood of restoring customary forms of love as a practice of healing from past trauma:

> "I love my kids with my whole heart. Oh, I tell them every day... like 'cause when I was growing up I was never told that 'I love you, I love you', right? Cause that's how we're brought up in the Residential School... We were never, never interacted [with] like that, right? We were numbers."

Developing strategies to manage ongoing anxiety of CPS's surveillance was another dimension of coping pointed to by Indigenous participants who were currently parenting children. For example, Leila (Indigenous, 49 years), who had extensive involvement with the system since birth, the fear of mandated reporting systems, like schools, meant she feared being even a few minutes late to pick up her child at school could re-open a CPS investigation, and spoke of a regular worthiness practice to help her carry on: '[I keep] telling myself I can do this...that I'm worthy of this. I'm worthy of loving my kids'.

Spiritual practices were another component of women's healing, especially for Indigenous participants, for whom spirituality incorporated important forms of cultural resilience and healing. As Esther (Indigenous, 51 years) stressed, her traditions have always been a strength for her, comparing them to the generative force of a blossoming flower:

> "I've always had my traditions. My grandmother... I'm a hereditary medicine line. And my grandmother was the knowledge keeper of our tribe. So, for all that dysfunction, my traditions are the budding rose."

Importantly, in Indigenous cultures, where many traditions are based on relationships with land, co-occurring losses of family, land and Indigenous knowledges are interrelated (Simpson, 2011), the revitalization of relationships with each dimension were emphasized in some narratives as essential to healing. At the end of her interview, Esther (Indigenous, 51 years) put forward a vision for widespread cultural and land-based healing villages for Indigenous families to 'get rid of the trauma'. As she put it unambiguously: '[We need to] get our culture back, 'cause that's what's gonna heal us'.

DISCUSSION

Our findings identify four trajectories that often co-occurred to influence sex workers' health in the aftermath of child removal, increasing their risk of poor health and reinforcing their conditions of marginalization. First, women's accounts described how child removal generated severe mental distress, articulated in experiences of depression, anxiety, grief and substance use, which had multiple immediate and enduring impacts on health. Second, the aftermath of child removal was interwoven with worsening poverty, including homelessness, that also introduced detrimental and far-reaching risks for health and safety. Third, women faced increased social isolation and displacement, undermining access to positive support as resources for health and rebuilding their families. Fourth, amidst indisputably difficult circumstances, many women maintained a continuity of presence with their children, taking up opportunities to regenerate and preserve family and cultural bonds, which were vital strategies to support their well-being. Notably, while both Indigenous and non-Indigenous sex workers had similar post-removal trajectories, Indigenous

women were more severely jeopardized. This was particularly evident in how colonial histories of family separation distinctly exacerbated Indigenous women's mental distress, and also in their experience of disproportionate post-removal poverty, which due to generations of systemic neglect and much higher rates of violence in this population, represented an especially high-stakes consequence (National Inquiry into Missing & Murdered Indigenous Women & Girls, 2019).

Building on evidence of links between child removal and increased adversities among sex workers (Dewey et al., 2018; Dodsworth, 2014; Jackson et al., 2007; Jeal et al., 2008; McClelland & Newell, 2008; Thumath et al., 2020), our analysis offer insights largely absent in the empirical literature on how child removal can unfold wide-ranging threats to the health of marginalized women. Consistent with the stress process model (Pearlin et al., 1989), our analysis suggests that child removal not only triggered severe mental distress that directly influenced sex workers' health, but additionally gave rise to a chain of secondary adversities, such as homelessness, that also introduced profound and far-reaching risks to health. Here, the stress process paradigm's conceptual distinction between the primary traumatic stressor of child removal, and the proliferation of additional adversities undermining women's health, helps to illuminate the array of negative life trajectory-related consequences exemplified by our data, and further, points to how women's longer-term health and well-being can be differentially affected by the same event (Pearlin et al., 1981). In this way, our results also align with expectations of the stress process model, in suggesting that the violent burden of colonialism and related structural inequities (Million, 2013) help explain why child removal appeared more threatening to the health and safety of Indigenous sex workers compared to non-Indigenous sex workers in our study. Taken together, our findings suggest that the health consequences of child removal may have greater reach than previous health research suggests (Haight et al., 2002; Kenny et al., 2015; Nixon et al., 2013; Wall-Wieler, Roos, Bolton, et al., 2017; Wall-Wieler, Roos, Brownell, et al., 2017; Wall-Wieler et al., 2018), by extending beyond the mechanism of mental distress and related health sequelae, to also fundamentally alter women's social conditions, revealing additional mechanisms undermining maternal health that have been poorly understood to date.

To support a wider reading of CPS's policies of child removal with attention to what they produce for women's health, the concept of 'slow violence' helps in further interpreting the toll on health as a reverberating form of structural violence (Nixon, 2011). Through this lens, sex workers' accounts of eroding health and social conditions, add to evidence of the slow violence of child removal (De Leeuw, 2016) by tracking how it permeated across multiple life domains to harm health. Paralleling Springer's (2012) assertion that when 'we bear witness to violence, what we are seeing is not a 'thing', but a moment with a past, present and future' (Springer, 2012), our findings foreground women's trajectories of deteriorating health as critical to understanding how the slow violence of child removal can gain momentum in the lives of marginalized women. Unlike more visible or newsworthy violence, these forms of slow-acting violence, such as post-removal homelessness, may be difficult to source, likely perceived instead as disparate events that lack underlying connection to their institutional origins, and, as such, posing challenges to how they are understood and responded to (Lee, 2019). For sex workers, this invisibility is also embedded in stigmatized and moral assumptions about sex workers, framing them as inherently dangerous to their children (Dewey et al., 2018; Dodsworth, 2014) and normalizing their experiences of violence (Krusi et al., 2016). In this context, the reverberating harms of child removal may also be framed as an under-recognized processes of social 'erasure' (Namaste, 2000), a concept that refers to how institutional and social processes collude in further marginalizing and regulating the daily experiences of marginalized women as criminalized citizens, while also rendering their existence as mothers increasingly impossible (Dewey et al., 2018).

Significantly, for Indigenous participants, the slow violence of child removal was also constitutive of ongoing colonial violence towards Indigenous families. For De Leeuw (2016), this slow violence taking place in the intimate and hidden spheres of Indigenous homes, and especially on the bodies of Indigenous women and children, represents a productive way for understanding how colonial institutions like CPS obfuscate dispossession of and violence towards Indigenous peoples, particularly in settler-colonial societies where these assaults are not typically viewed as violence at all (De Leeuw, 2016). Further, for Indigenous mothers, for whom generation upon generation of losses of home and family ties are ontologically rooted in genocidal colonial policies, our findings of the mental, physical and spiritual violence of child removal also provides important evidence of what Thistle (2017) terms 'Indigenous homelessness' (Thistle, 2017). Unlike colonial definitions of homelessness, which define a lack of a structure of habitation, Thistle (2017) considers the plight of Indigenous homelessness through a composite lens of Indigenous worldviews, encompassing losses of relationships to land, water, place, family, kin, animals, cultures, languages and identities. Through this lens, the multiple forms of 'homelessness' produced by child removal for Indigenous women and the challenges of re-locating/building 'home' are more accurately elucidated, providing clearer policy directives for Indigenous-led initiatives for healing and justice to prevent and redress the harms of family separation through revitalization of cultures, knowledges, land connections and pre-colonial models of Indigenous societies (Lavell-Harvard & Corbiere-Lavell, 2006; Simpson, 2011).

Our study highlights a typology of four trajectories trajectories through which child removal influenced sex workers' health, increasing their risk of poor health and adding to their conditions of marginalization in ways that were distinctly jeopardizing for Indigenous women. Findings offer a framework for conceptualizing this relationship, not as a single calamitous event in the lives of marginalized women, but rather as one that unfolds and is strengthened by perpetuating other forms of violence that can lead to a layering and compounding of health harms over time. Findings have implications for racial inequities in health by illuminating processes through which child removal policies—a central modality of colonial power—may act to reproduce health inequities burdening Indigenous peoples. Though our sample is limited to a demographic of sex workers living in poverty, the consistency of CPS policies across a majority of jurisdictions of the global north and the marginalized status of those most affected make it likely that dynamics identified here are not unique to this population. Future research should examine how these processes unfold among sex workers in other segments of the sex industry, as well as among parents who use drugs, migrant parents, parents with disabilities and other disproportionately affected groups.

CONCLUSION

In this paper, we demonstrate the potential long-reach of child removal events through examination of their cumulative and detrimental influences on the health of marginalized mothers. Our findings highlight the importance of interventions and social transformation efforts to promote the well-being of sex workers and their families, including sex worker and Indigenous-led family support and preservation services, and in cases of removal, post-removal health, housing, legal and culturally based supports to mitigate harms to women's health.

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AUTHOR CONTRIBUTIONS

Kathleen S. Kenny: Conceptualization (lead); Data curation (lead); Formal analysis (lead); Funding acquisition (supporting); Investigation (lead); Methodology (lead); Writing-original draft (lead); Writing-review & editing (lead). **Andrea Krusï:** Data curation (supporting); Project administration (lead); Resources (supporting); Writing-review & editing (supporting). **Clare Barrington:** Conceptualization (supporting); Formal analysis (supporting); Investigation (supporting); Methodology (supporting); Supervision (supporting); Writing-original draft (supporting); Writing-review & editing (supporting). **Flo Ranville:** Data curation (equal); Investigation (equal); Writing-review & editing (supporting). **L. Sherri Green:** Conceptualization (supporting); Funding acquisition (supporting); Investigation (supporting); Methodology (supporting); Supervision (lead); Writing-original draft (supporting); Writing-review & editing (supporting). **Brittany Bingham:** Writing-review & editing (supporting). **Ronald Abrahams:** Writing-review & editing (supporting). **Kate Shannon:** Conceptualization (supporting); Data curation (lead); Formal analysis (supporting); Funding acquisition (lead); Investigation (supporting); Methodology (supporting); Project administration (supporting); Resources (lead); Supervision (supporting); Writing-original draft (supporting); Writing-review & editing (supporting).

DATA AVAILABILITY STATEMENT

The data are not publicly available due to ethical restrictions.

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